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# Reverence for Life in Severe and Terminal Illness: A Theological Ethical Viewpoint

Since the turn of the 20th Century our society has experienced important advances in medical science. During the first half of the century, the development of antibiotics and increasingly sophisticated medical treatment programs have combatted illnesses such as small pox, tuberculosis, typhoid, cholera, polio, hepatitis and plague which were once regarded as terminal illnesses.[1] Yet, more striking advances have emerged gradually over the last half of this century in the form of a highly technocratic practice of medicine.

People today are well aware of organ transplants, heart-bypasses, new drug therapies administered orally and intravenously, intravenous nourishment, blood transfusions, and the use of sophisticated respirators, hemo-dialysis and electric resuscitation. New medical approaches and life support techniques continue to be explored in an effort to provide care for severely ill and terminally ill persons. With this new technology, human beings have literally been given the choice as to whether the life of the severely ill or terminally ill patient should be extended or should end. The availability of this choice has led to profound ethical dilemmas.[2]

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[1]See Robert C. Atchley, *Social Forces and Aging* (Belmont, CA: Wadsworth, 1985) pp. 23-24; and Stephen E. Lammers and Allen Verhey, eds., "Life and Its Sanctity," *On Moral Medicine* (Grand Rapids: Wm. B. Eerdmans, 1987), p. 107.

[2]Lammers and Verhey, "Life and Its Sanctity," p. 107, and Atchley, *Social Forces*, p. 224.

The dilemmas surrounding dying and death decisions have brought bioethical considerations to the forefront. Over the last decade and a half, a strong emphasis in bioethics has been that of patients' rights and informed consent. However, the implementation of these actions has not been problem-free. There has tended to be a pervasive silence that surrounds issues of dying and death. Disagreements have erupted between patient, medical professionals, and family members on what course of action to take. There have been difficulties with regard to respect of the patient's autonomy in cases where they have shown diminished capacity for decision-making. In some instances decisions have not always been made that were within the realm of legal propriety, while at other times, the legal system has mandated actions contrary to the wishes of families.

Often there has been the tendency of medical professionals and families of severely and terminally ill patients to treat these patients in a "paternalistic" fashion. That is, medical professionals or family members have tended to act for them on the basis of what they considered the patient's "best interest" rather than respecting the patient's autonomy.[3]

The intent of patients rights has been to allow persons to determine the actions to be taken on their behalf that are consistent with their understanding of respect for life, quality of life, or death with dignity. But bioethical considerations have emerged as complex issues. There are no easy answers to life and death decisions and there is no present social consensus on such matters. Moreover, the response of the legal system has been contradictory in that it sometimes sets limits while on other occasions, it reflects

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[3]Harry R. Moody writes specifically with reference to older adults, but his statements are equally applicable to the situation of the terminally ill in other life stages. See Harry R. Moody, "Ethics," in *Encyclopedia of Aging*, Robert C. Atchley et al. (New York: Springer, 1987), pp. 224-227.

the societal ambivalence.[4] The wide variability in decision-making is evidenced in the experiences of persons in the following three life and death situations.

*Case Illustration # 1*

Bobby A., a 16 year old male, was rushed to the hospital with a high fever, severe headache, and difficulty in moving his extremities. Over a period of nearly a week, extensive tests provided no conclusive diagnosis. Shortly thereafter, he developed violent seizures. During one of the seizures his heart stopped, but he was resuscitated. He lapsed into a deep coma and was placed on life support systems when it was determined that he had difficulty breathing on his own and there continued to be troubling irregularities in heart functioning. Bobby's parents were told that his prognosis was not good and that, should he survive, he would probably be in a vegetative state.

Bobby's condition worsened and he was functioning only minimally on his own. The life-support systems were ostensibly doing the work for him. His parents were asked to decide whether to continue the supports or to allow him to die peacefully. They chose to maintain the life supports because they said, "Where there is life, there's hope."

Over a period of two months on life supports, Bobby's temperature became stabilized, yet he remained in a coma. They participated in his care by talking and reading to him, stroking him, and praying aloud at his

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[4] *Ibid*, p. 225.

bedside. In talking with the parents outside the hospital, they spoke of their quandary over how they would be able to pay the medical bills since Mr. A. was self-employed and had minimal health insurance. But they were elated when their church began a fund for their son. They viewed this action as confirmation of their decision to maintain Bobby on life-supports. They continued to be adamant that the life support systems continue.

After remaining on life supports for a period in excess of six months, Bobby began to show signs of improvement. The decision was made to remove the life supports for a short period of time daily to monitor his ability to function on his own. The amount of time off of life supports was increased daily. It was finally determined that he could function without the supports. The depth of his coma had also lessened and he was more responsive to stimuli, but he remained in a vegetative state. Bobby was finally released to the care of his parents and nursing assistance at home, though in this state. Six years have passed since his illness began. His parents and others still care for him at home in that state today.[5]

*Case Illustration #2*

Reverend S., a 68 year old male, was diagnosed with terminal cancer. After three hospitalizations, two surgeries, and chemotherapy over a six months period,

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[5]This case illustration recounts a story of a family that lived near me some years ago.

he and his family were told that the disease had not been arrested and that it had spread to other organs and the lymphatic system. The doctors indicated that the option for chemotherapy was still open and that its use had the potential for at least slowing the progression of the disease. At first the family was stunned by the news they were given. For a time they seemed to be "frozen" in silence. But, Reverend S. broke the silence and made clear that he had given much thought and prayer to his situation and wished no further treatment. He expressed his desire to his family and his doctors that he wanted to die with dignity at home. He also said that he was not afraid to die, because he believed that Jesus Christ had gone ahead to prepare a place for him at the welcome table.

The family of Reverend S. affirmed his decision. He and his family also began to talk about what alternatives they had open to them for giving him the care he would need once he came home. He was cared for at home by his family members and Hospice caregivers.

Throughout the six months that followed, Reverend S., his family, and members from former churches he had pastored, spent time sharing, crying, hoping, and finally facing the reality of his impending death. Reverend S. also continued nearly to the time of his death to lead the family's nightly devotions. Toward the end, he gradually lost his voice. He finally lapsed into a coma and died.[6]

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[6]This case illustration summarizes experiences of dying and death with my father.

*Case Illustration #3*

> Lester Z., a twenty-three year old New Jersey resident, shot his brother to death three days after the latter had a motorcycle accident that left him paralyzed from the neck down. Twenty-six year old George Z. lay on a hospital bed when his brother entered the intensive care unit with a shotgun concealed under his coat. "I am here to end your pain, George," he said. "Is it all right with you?" According to Lester's testimony, the brother "nodded, yes." There were no witnesses. Lester was acquitted after a plea of insanity.[7]

In these case illustrations there is a sense that the life and death decisions were based on some understanding that the decision-makers had about reverence for life. However, there was clearly no uniformity in the decisions made in the three cases. The decisions in the first two cases were made collaboratively, while the decisions in case illustration #3 was autonomous. A clearly definable compassionate community was present in the first two cases, whereas in the third case no apparent community was involved. These cases raise crucial questions not only about how one should make life and death decisions, but also about the context in which the decision and its follow-up occur.

The position here is that theological ethics can provide a framework for considering life and death decisions. Moreover, for

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[7]This case study is found in Richard G. Benton, *Death and Dying: Principles and Practices in Patient Care* (New York: Van Nostrand Reinhold, 1978). pp. 40-41.

Christians the formation of this framework happens in a "community of compassion" within which reverence for life is the central thrust of moral discourse.[8] That is, a community of compassion is one that should point to activity that brings to reality a reverence for life in life and death decisions; and this activity ought to be shaped by Scripture, including our understanding of God and Jesus Christ as well as reflection on human experience.

The model of decision-making presented here takes seriously the reflection on case illustrations #1 and #2. These two cases are examples of how ethical decisions are made within the context of a compassionate community. It is on the basis of reflection on these two cases and on the metaphor of community of compassion rooted in Scripture that the model of Christian decision-making is developed.

Case illustration #3 provides a contrasting autonomous approach to decision-making. This contrasting approach helps to highlight the importance of a collaborative model.

In the following sections the intent is to examine the meaning of the key metaphor of "community of compassion" and explore answers to the following questions that give shape to such a community: (1) How may we think theologically about the term, "reverence for life"? (2) In what ways does Scripture inform meanings assigned to the terms "reverence for life" and "community of compassion"? (3) What should be the processes and guidelines for fulfilling a "community of compassion" within which reverence for life is shown in making decisions about life and death in cases of severe or terminal illness?

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[8]See James M. Gustafson, *Ethics from a Theocentric Perspective, Vol II—Ethics and Theology* (Chicago: University of Chicago Press, 1984), pp. 316-317.

## A Community of Compassion

First, to refer to community is to refer to an experience of persons set in motion together by a vision of what life is to be like and, in a real sense, what death is to be like. Community is an experience of persons who are radically present to one another and who are committed to mutual relationships that exhibit trust, care, support, and encouragement. In this way, community is understood, more precisely, as a *community of compassion* where there is an expression of terms of endearment or compassion through *agape love*.

Specifically, in the context of community as an expression of *agape love*, compassion is expressed in persons' selfless love toward others through their entering into the experiences of others and feeling with them. It implies in-living or living in solidarity with severely ill or terminally ill persons and their families through thought and love.[9] This deeply felt sense of solidarity with suffering makes it possible for severely ill or terminally ill persons and their families to be sustained in their search for authentic understanding of their situation, and in their confrontation of life and death decisions.[10] This means that a community of compassion is also *a community of solidarity*.

Second, to refer to a community of compassion is to refer to a *community of moral discourse*. Reference here is specifically to the Christian community. Within the Christian community as a context for moral discourse occasions are provided for the formation of the "consciences" of persons in the area of dying and death, to educate their rational activity regarding it, and to enable them

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[9]Thomas Dubay, *Caring: A Biblical Theology of Community* (Denville, NJ: Dimension Books, 1973), pp. 56-57.

[10]Rodney J. Hunter, *Dictionary of Pastoral Counseling* (Nashville: Abingdon, 1990), pp. 206-207.

to think more clearly and thoroughly about the moral dimensions of life and death decisions consistent with Christian teaching and tradition.[11] The community of compassion, then, is a community of discourse.

Third, the community of compassion is also a *community of discernment*. This refers to collaborative participation in seeing what the appropriate choices are that need to be made regarding terminally ill or severely ill people. What is the right course of treatment? What should or should not be done? It is out of the moral discourse within the community of compassion that discernment or envisioning alternatives come.

Finally, the community of compassion is a *community of listening*. Persons of compassion are genuinely interested in those who suffer and face hard decisions; and interest is exhibited when persons are eager to listen and slow to speak. Interest proved in love is an expression of love. It is concern shown about the welfare of others as well as one's own. To listen assumes that when terminally ill or severely ill persons are able or have the occasion to speak, the statements they make are revelatory of their person. Likewise, there is a revelatory nature in the sharing of the family members of such persons.[12] The entrance of the Christian community into the experiences of the terminally ill and severely ill happens as persons are energized by a Christian understanding of reverence for life. Conversely, reverence for life is deepened as persons in this community participate compassionately in the experiences of the suffering, dying, and death of others. Several corollary motifs are connected to the root metaphor of the "compassionate commu-

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[11]Gustafson, *Ethics from a Theocentric Perspective*, p. 316.
[12]Dubay, *Caring*, pp. 66-67.

nity," which are descriptive of attitudes and ways of being that reflect reverence for life.

### Respect for Life and Persons

Karl Barth insists that it is God's command that life be accepted, treated, and preserved with respect.[13] Indeed, from his perspective, God commands that we respond to God's gift of life through our solidarity with others and through our exercise of stewardship over life.[14] While I agree that life is a gift of God and must be respected, I believe that this respect must go beyond a theoretical formulation. It must become actualized in terms of how we concretely act with and on behalf of persons.

Thomasma contends that respect for persons is exemplified by fulfilling the moral obligation to promote well-being.[15] In his way of thinking this entails two ethical guidelines: to acknowledge autonomy and to protect those with diminished autonomy. At the same time, respect for persons entails seeing and caring for the whole person. This assumes that there are personal, psycho-social, and spiritual aspects in the nature of persons that require response.

A second position is set forth by Hauerwas in which respect for persons recognizes that life has a purpose beyond being "autonomous." Based on his perspective, it can be said that life and death decision-making can be distorted by an ethics of autonomy exercised either by the terminally ill or severely ill patient, or by significant others. This kind of distortion is illustrated in cases of active euthanasia or mercy killing, an example of which appeared earlier in case illustration #3.

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[13]Karl Barth, "Respect for Life," in *On Moral Medicine*, p. 109.
[14]*Ibid.*, 113-116.
[15]David C. Thomasma, "The Basis of Medicine and Religion: Respect for Persons," in *On Moral Medicine*, p. 289.

An important point in Hauerwas' perspective is if our focus is unduly on individual rights, then we fail to recognize our existence in community and the compassion that can be given there. Likewise, if the community fails to see and reach out to those who hurt, then the community has failed in its mandate to respect persons. An additional point is that respect for persons recognizes that "our existence is not secured by our own power, but rather, it requires the constant care and trust of others."[16] Through our intentional relationships with others in life and death, we tap into the incarnational Presence of God.

A third viewpoint is expounded by Moody. It is his view that decisions made on a collaborative basis rather than on individual judgment can also have dangerous limitations if the collaboration is in the socio-political arena. The danger is that "respect for persons" can become reframed as "worth of persons." In our era of cost containment, this kind of reframing gets acted out in a utilitarian ethical perspective in which life and death decisions are made on the basis of the deferential assignment of "worth" to certain groups of people. This denies an understanding of the intrinsic worth of all persons that is associated with a respect for all persons.[17]

All three positions bring important elements to bear on our reflection on whether the actions of persons are indicative of reverence for life. However, the bias here is toward the Christian community as a community of moral discourse though differing points of view are exposed and persons can think through their positions and the actions that flow from them.

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[16]Stanley Hauerwas, "Rational Suicide and Reasons for Living," in *On Moral Medicine*, p. 463.

[17]See Moody, *The Encyclopedia of Aging*, p. 226-227.

## Death With Dignity

What is the meaning of the phrase, "death with dignity" and what are the possibilities and limits of its use? Benton defines death with dignity as the position taken by advocates who stress the need of persons to die while shreds of humanity remain.[18] Characterized by Reverend S. in case illustration #2, it includes the refusal of treatment as well as the provision of assistance toward death after all hope of recovery is gone.

Morrison as well indicates that dignity derives from relinquishing the control that technology imposes. He poses the basic question as to whether or not the dying process can be carried out with dignity. His viewpoint is that the omission of heroic efforts to save or prolong life can have the effect of sparing persons from dying with indignity. He states that

> ...at a certain stage in the process of dying, it is basically *un*dignified to continue casting desperately about for this or that potion, philter, or device to prolong some minor sign of life, after all reasonable chance for the reappearance of its major attributes have disappeared. ...(There is) something offensive about this frantic search for some last remedy, some magic wire to hook up merely to postpone the inevitable.[19]

Leon Kass contends that "death with dignity" is a slogan that suggests that there are more or less dignified ways to face death

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[18]Benton, *Death and Dying*, p. 74.
[19]Robert S. Morrison, "The Last Poem: The Dignity of the Inevitable and Necessary," in *On Moral Medicine*, p. 197.

or to die.[20] In his view it is true that dying with dignity can be assaulted, undermined, or eliminated by external happenings such as the uses of life support measures or treatment that exceed the benefits derived from them. However, death with dignity has to do with more than the absence of external indignities. For him dignity comes from within and from the soul.[21] Dignity cannot be conferred externally. It must come internally.

One may agree that refusal of further treatment and life supports in terminal and severe illness is a humane approach and makes death possible with dignity. It may also be agreed that there are internal dimensions that are at work in how one experiences dignity. However, neither of these views confronts the questions of whether withholding treatment actually means that a person will die with dignity, or whether it simply means that he or she will die sooner. Also there is question of how the decision is made by those who are not in a condition to have input into the decision.

Finally, the positions do not respond to the refusal of treatment that one thinks may result in death. However, because of the will of the person and/or family, the refusal of treatment may result in the regeneration of life with dignity rather than the deterioration of life. It is all of these questions that are important to place in the community of moral discourse.[22] In case illustration #1 the decision of Bobby's parents and doctors to withdraw the life support systems was confirmed by the Christian community. But, he did not die, nor did he return to normalcy. However, the quality of life for Bobby improved because he was surrounded by a caring and supportive community.

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[20]Leon R. Kass, "Averting One's Eyes, or Facing the Music?—On Dignity and Death," in *On Moral Medicine*, p. 201.
[21]*Ibid.*, p. 202.
[22]See David Dempsey, *The Way We Die: An Investigation of Death and Dying in American Today* (New York: McGraw-Hill, 1975), pp. 120-123.

To summarize, one approach to respect for life is to allow people to die with dignity. But the issue is complex and must be examined within a community of compassion. For Christians, this means looking at the biblical sources of respect and reverence for life to inform the discourse in community regarding life and death decisions.

### Scriptural Bases for Reverence for Life And Compassionate Community

For Christians, reverence for life and an understanding of a community of compassion are expressed biblically in a number of ways. God's reverence for human life is shown in the very creation of human life by God:

> In the day that the Lord God made the earth and the heavens, when no plant of the field was yet in the earth and no herb of the field had yet sprung up—for the Lord God had not caused rain upon the earth, and there was no one to till the ground; but a stream would rise from the earth, and water the whole face of the ground—then the Lord God formed man from the dust of the ground, and breathed into his nostrils the breath of life; and the man became a living being. (Genesis 2:4b-7 in the *New Revised Standard Version)*

Humankind was also created by God in God's image. (Genesis 1:26-27) God's affirmation of human life and value is made concrete by this act of creation. In God's act of creation, life was given as gift; and as gift, human life is to be nourished, cared for, protected, and developed. The value assigned to human life by God is not predicated on age, status, or pragmatic utility. In all instances the grounds for valuing and revering life is found in the

richness of the symbol "image of God."[23] In God's creation of human life in God's image, God initiated relationship with humankind. God's covenantal relationship with humankind invites response through the solidarity of persons with one another and the exercise of their stewardship of life in the care of their own and other's lives.[24] Stewardship in relationship is, in fact, a matter of persons' treatment of the gift of life that is given by God. Included within it is spontaneity of persons, which means freedom to take responsibility, to adopt modes of action, and to exercise deeds that correspond to the understanding of life given to one another as gift and a trust to be respected and cared for.[25]

Reverence for and responsibility taken for human life is placed in the context of the finiteness of mortal life. God created people whose earthly life would end in death, as indicated in Genesis 6:3: "And God said, `My spirit shall not abide in man forever, for he is flesh, and his days shall be a hundred and twenty years.'" Death is also confirmed as part of the order of the world. Accordingly, God made persons from the dust of the earth and to dust they must return. (Genesis 2:7 and 3:19) Biblical confirmation of human finiteness is critical because the knowledge of our death influences our view of life. Barth reminds us that the biblical message is concerned with the eternal life of persons. He places his viewpoint in the context of God's gift of life that is lent to humankind, but that is also given

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[23]J. Robert Nelson, *Human Life: A Biblical Perspective for Bioethics* (Philadelphia: Fortress Press, 1984), p. 161.

[24]Barth, "Respect for Life," *On Moral Medicine*, pp. 113-116; General Commission on Christian Unity and Interreligious Concerns of the United Methodist Church and the Bishops' Committee for Ecumenical and Interfaith Affairs, National Conference of Catholic Bishops, "Holy Living and Holy Dying," p. 5.

[25]Barth, "Respect for Life," *On Moral Medicine*, p. 116.

> as an enduring and inalienable possession, as everlasting life. But even in this new mode it will still be life, and indeed human life. If it is the case that man is to enter into this his new life by the resurrection of the dead, if this entrance and transition take place as this corruptible puts on incorruption and this mortal immortality (1 Corinthians 15:23), then this eschatological aspect, the limitation of this life by the eternal, does not signify a devaluation, when it is correctly understood, a proper evaluation even of this corruptible and mortal life.[26]

Persons' beliefs about whether life continues after death inform their understanding about reverence for life. Kelsey contends that when persons believe that dying leads to total extinction or to utter nothingness, it is difficult for them to see any final meaning in their lives and it becomes difficult for them to be faithful to any system of ethics or morality.[27] The denial of life after death serves to focus people's behavior on a purely materialistic basis, so that when this basis is threatened by terminal or severe illness, the result is often despair, or even suicide; and in this case, reverence for life is disavowed.

The central theme of the New Testament is that the resurrection of Jesus reflects the ultimate purpose of our life as one of union with God in the life to come, to the eternal value of the human body, and its emotions, and to the continuation of life on a new, transformed level.[28]

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[26] *Ibid.*, p. 117.

[27] Morton Kelsey, *Afterlife: The Other Side of Dying* (New York: Paulist Press, 1979), p. 18.

[28] "Holy Living and Holy Dying," p. 6; Kelsey, *Afterlife*, pp. 151-152; Paul Badman, "Death" in *Westminster Dictionary of Christian Theology*, eds. Alan Richardson and John Bowden (Philadelphia: Westminster Press, 1983), p. 146.

The essentials of caring in the exercise of a compassionate community is found throughout the New Testament. In Romans 15:2, the Apostle Paul entreats us to try to please our neighbor and in Philippians 2:4, he emphasizes looking after the interests of others rather than our own.

The compassionate living out of our understanding of the sufferings and concerns of others is also given direction by Paul's focus on our having the same mind that is in Christ Jesus who emptied himself to become a servant even to the horrifying death of the cross (Philippians 2:7-8). The concerns of others are to dwell in our hearts (2 Corinthians 7:3; 1 Thessalonians 2:17; Philippians 1:7); and in like manner as the first disciples, we are to be devoted to community and to show care for its members (Acts 2:42). We are to be the incarnational presence of Jesus Christ, who felt sorrow and compassion (Matthew 6:34; Matthew 15:32; Luke 7:13).[29] In so doing, we show reverence for life and the meaning of a community of compassion.

## Process and Guidelines for Fulfilling A Community of Compassion

In this final section the intent is to propose a process and guidelines for fulfilling a community of compassion in which the elements of solidarity, listening, moral discourse, and discernment are brought to bear upon situations of dying and death where moral decisions are required. This will be done by bringing together elements of the human experiences contained in the case illustrations, understandings of the guiding metaphor, "community of

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[29]The applicability of these scriptural references to life in community is explored by Dubay, *Caring*, p. 55-60.

compassion," and the correlative motif of reverence for life, and biblical bases for actualizing a community of compassion.

## The Process

An important starting point for a process aimed toward actualizing a community of compassion is that of breaking the silence surrounding dying and death so that the issues that require moral decisions can be looked at critically and decisions made from an informed stance.

*Breaking the silence.* In case illustration # 2, the family of Reverend S. was "frozen in silence" when confronted with his impending death. Although the family finally emerged from this silence when Reverend S. pierced it with the expression of his desire to die with dignity, the typical response to death and dying by persons in our society is one of "heavy silence," as May calls it.[30] The position here is that the actualization of a community of compassion and the authentic expression of reverence for life and respect for persons cannot happen in a context of silence. But how is it possible to break the silence?

For many people in today's society the beginnings of the process of breaking the silence may involve confronting feelings of the awesomeness of death itself. A part of this may entail questioning whether material existence has been embraced to the exclusion of solidarity. It may also mean recognizing that when we embrace material existence we separate ourselves from the incarnational presence of Christ through which we are affirmed, respected, and sustained, as well as given hope for ongoing life after death.

The essential matter in breaking the silence is not simply in confronting the questions raised. It is being present to and

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[30]See William F. May, "The Sacral Power of Death in Contemporary Experience," in *On Moral Medicine*, p. 175.

listening to the real life and death dilemmas that people face. For example: it was only when Reverend S. was listened to by the family members that the family together was able to act on the decision for no further treatment and to make the necessary plans for providing care that assured respect and dignity in the dying process. Likewise, it was only when the Christian community of which Bobby A, in case illustration #1, heard his parents' story of suffering that they could see new hope for Bobby's future, even if that future meant his being in a vegetative state. So the process of breaking the silence means standing in solidarity with persons who suffer and listening to their stories.

Breaking the silence opens the way to moral discourse and discernment. The position here is that moral discourse and discernment are best undertaken within the context of a community of compassion, which the Christian Church is called to be. Within that context we may consider whether medical technology exists as a concealment of our inner sense of bankruptcy before death, or whether technology assists God's efforts to continue life, or whether the technology is an interference in God's intent for the order of human life.

In the context of the compassionate community of discourse and discernment, as Christians we may also ask the question of whether or not we believe God to be a "Hangman God," or a God who initiates relationship with us, acts concretely in our lives, and continues in solidarity with us throughout our mortal life and into the hereafter.

In case illustrations #1 and #2 there is the implicit message that life and death decision-making is a complex enterprise. However, when there is an atmosphere and an opportunity for sharing, myriad questions can be raised by the terminally ill or severely ill person and family members. It is likely that the two families in the case studies raise such questions as: Should life supports be needed, how long can life be sustained by these supports, and what would

be the quality of this life? Is it feasible to undergo numerous surgeries and treatments if there are questionable results? What difference will the treatments make? Will there be much pain and suffering? What expense will be involved? Will the needs of family members be met when death occurs and financial resources are used up by medical expenses? Who decides what actions should be taken in the event of coma or diminishing capacity? Would the natural death course be preferable to artificial life in the case of clinical death? What other burdens would be imposed on the dying self and family members? Should a living will be executed?

In case illustration #2 Reverend S. and his family were open in their struggles with the moral decision that they had to make. In addition, there was an openness about sharing the faith perspective that undergirded their decision and about how they would relate until his death.

In summary, reflecting on the cases helps to illustrate that the process of moral decision-making in life and death situations takes place best in a supportive community. This supportive community also functions well when it has deep roots in a faith tradition that undergirds the reverence for life and dignity in death. Moreover, the supportive compassionate community provides a context through which difficult decisions can be made that affirm all persons as they face the inevitability of life's end.

The fact that terminally ill and severely ill persons and their families have a compassionate and supportive community does not necessarily mean that their life and death decision are influenced by that community. What it does mean is that the community is present to them, listens to them, engages in moral discourse with them, and participates with them in the discernment process.

Christians do not always act as a compassionate community in solidarity with the terminally ill and severely ill persons and

their families. Nevertheless, the command of God is that responsibility must be taken for these persons and their families by the community that calls itself by the name of Christ.